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AUTHOR Kreps, Gary L.
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ABSTRACT

Interpersonal communication plays an important role in health and health care. Five topic areas of problem-oriented interpersonal health communication research demonstrate this important role: lack of patient compliance, miscommunication and misinformation, insensitivity, unrealistic and unfulfilled expectations, and dissatisfaction. More recently, research in interpersonal health communication has examined the social support functions of interpersonal communication in health care. These studies have demonstrated the need for expressive social communication contacts with others to help maintain individual well-being and psychological health. Unfortunately the focus of research studies thus far has been on the interpersonal communication needs of health care providers, often ignoring the interpersonal communication needs of health care consumers, different specialized areas of health care delivery, and the aged. Future research should be designed to (1) identify the specific communication competencies needed by people involved in digestive disease health care, (2) establish performance-based measures for health communication competencies, and (3) develop educational strategies to help health care consumers and providers cultivate the health communication competencies identified. (HOD)

"Interpersonal Communication in Health Care: Promises and Problems"

Gary L. Kreps

Department of Communication

Rutgers University

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Abstract

This paper provides a selective analysis and critique of the research area trends concerning the role of interpersonal communication in health care. Different areas of interpersonal health communication research are identified and discussed. Limitations of past research to provide a useable integrated model of interpersonal health communication proceses is examined. An integrating perspective for interpersonal health communication research and development concerning development of health communication competencies for both patients and providers is suggested.

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Introduction

Interpersonal communication plays an important role in health and health care. Effective interpersonal communication between people involved in health care situations can help promote the delivery of high quality health care, while ineffective interpersonal health communication can seriously deter the quality of health care delivery (Cline, 1983; Kreps and Thornton, 1984). It is at the interpersonal level of health communication that meaningful relationships are established between those individuals who are seeking and providing health care services. Relationship development in health care services facilitates the exchange of relevant health information, coordination of efforts, and provision of emotional support between interdependent health care consumers and providers (Kreps, 1985a). The failure to establish effective interpersonal relationships in health care situations is generally due to ineffective use of interpersonal communication. Ineffective interpersonal health communication has been shown to lead to dissatisfaction with health care services (Korsch and Negrete, 1972), alienation between health care providers and consumers (Lane, 1981), and excessive competition between health providers (Friedson, 1970; Frank, 1961).

Research concerning interpersonal aspects of health communication have been conducted in diverse settings over a wide range of topics. In this paper I will selectively review the different directions taken by several seminal pieces of research concerning interpersonal communication in health care. I will also suggest a promising direction for expanding, integrating, and applying future interpersonal health communication research.

Directions of Past Interpersonal Health Communication Research

Many studies have been directed towards examination of specific health communication practices and problems. For example, building on the early writing of Ruesch (1961; 1957; 1963), Ruesch and Bateson (1951), Rogers (1951; 1957; 1967), and Carkhuff (1967), research has explored specific strategies used in effective therapeutic communication such as communicating empathetically, and comfortingly with others (Pettegrew, 1977; Pettegrew and Thomas, 1978; Burleson, 1983; Northouse, 1977; Rossiter, 1975). This area of research has largely been concerned with identifying the specific interpersonal communication characteristics leading to therapeutic outcomes. The approaches taken and conclusions reached have been diverse, yet all studies support the contention that supportive and caring communication increases therapeutic outcomes.

A great deal of study has centered around planning and

directing interpersonal communication in provider-patient interviews (Cassata, Conroe, and Clements, 1977; Hawes, 1972a, 1972b; Hawes and Foley, 1973; Foley and Sharf, 1981; Arnston, Droge, and Fassl, 1978; Carroll and Monroe, 1980). Much of this research has been desigred to examine interperpersonal patterns indigenous to interview communication, identify specific communication characteristics used by health care providers to control interview communication, and develop strategies to help health care providers elicit full and accurate information from health care consumers. The research has tended to be pragmatic and applied to realistic concerns of information exchange in interview situations, but has also been limited in scope and applicability to the wide range of interpersonal health communication contexts other than provider/consumer interviews.

Several additional prominent topics of interpersonal health communication research have expressed a problem orientation to health care. These studies have attempted to link interpersonal communication to specific reccuring problems in health care. For example, five different topic areas of such research include:

1) lack of patient compliance (Lane, 1983, 1982; Stone, 1979; Charney, 1972; Dimatteo, 1979);

2) miscommunication and misinformation (Golden and Johnson, 1970; Ley, 1972; Waitzkin and Stoekle, 1972, 1976);

3) insensitivity (Kane and Deuschle, 1967; Lane, 1981; Daly

and Hulka; Korsch, Gozzi, and Francis, 1966; Korsch and Negrete, 1972);

4) unrealistic and unfulfilled expectations (Myerhoff and Larson, 1965; Blackwell, 1967; Mechanic, 1972; Fuller and Quesada, 1973; Walker, 1973);

5) dissatisfaction (Korsch, Gozzi, and Francis, 1968; Lane, 1983; Ben-Sira, 1976; Kane and Deuschle, 1967; Korsch and Negrete, 1972).

These five topic areas of problem-oriented interpersonal health communication research have clearly demonstrated the important role of human communication in health and health care. Moreover, these studies have identified several glaring deficiencies in the manner in which interpersonal communication is practiced in health care situations. Regrettably, however, most of these studies have done little beyond identifying these problem areas to plan, develop, and implement communication strategies for improving interpersonal health communication and relieving these problems.

A promising recent direction in interpersonal health communication research has examined the social support functions of interpersonal communication in health care (Droge, Arnston, and Norton, 1981; Albrecht and Adelman, 1984; Dickson-Markman and Shern, 1984; Cottlieb, 1981; Query, 1985). These studies have demonstrated the need for expressive social communication contacts with others to help maintain individual well-being and psychological health. The social support construct has become

very important as the American public has gradually taken increasingly more responsibility for their own health and health care, depended more on peers for health information, and begun widespread use of self-help groups for emotional, psychological, and informational health care services. Unfortunately, social support research remains largely unintegrated and unrefined with few consistent findings; diverse methods of study and operationalization have been used limiting comparisons of studies, and this potentially rich area of study remains relatively underdeveloped (Query, 1985).

Limitations of Past Research

Much of the research concerning interpersonal aspects of health communication have been conducted in the past quarter of a century, making this topic of research a fairly young area of inquiry. Due to the youth of this research area several key topics of study have not been fully explored, while other topics have received the lion's share of research attention. Additonally, much of the research that has been conducted on interpersonal issues in health communication have not been well integrated. Research has tended to focus on several small parts of the interpersonal health communication process without linking these parts together into meaningful configurations. Work needs to be done to examine, explain, and integrate past health communication research. (Kreps and Thornton (1984) and Thompson (1984) provide two pioneering examples of such

integrating work in health communication.)

The focus of attention in past health communication research has overwhelming been on the interpersonal communication needs of health care providers, often ignoring the interpersonal communication needs of health care consumers (Thompson, 1984). (A notable exception to this trend has been the recent research concerning social support networks that primarily examine the communication needs of health care consumers acting as providers.) Just as many applied organizational communication studies have tended to adopt a management orientation in terms of who the researchers serve with their research (Pacanowsky and O'Donnell-Trujillo, 1982), health communication research has often adopted a health care provider orientation. For example, compliance research has focussed on how providers can get consumers to follow instructions. The term "compliance" itself suggests a one-way power orientation with the consumer being responsible to the provider. Kreps and Thornton (1984) suggest redefining the issue of compliance into a relational issue of "cooperation" to fully take into account the interdependent commuicative functioning of health care provider and consumer.

Clearly consumers, as well as providers, of health care have important and challenging interpersonal communication needs in health care. For example, health care consumers need to use interpersonal communication skills to:

1) gather relevant health information about their health

problems and treatments;

2) elicit cooperation and respect from the health care providers that serve them;

3) collaborate with others to make complex and far-reaching health care decisions;

4) influence others to cope with the often-restrictive bureaucracy of the health care system;

5) cope symbolically with their health problems.

To help consumers achieve these interpersonal goals health communication research should focus on how to increase the effectiveness of both consumers' and providers' interpersonal communication in health care.

In addition to the overemphasis on studying health care providers to the expense of health care consumers, past studies in health communication have not examined the different commuication needs and problems of different specialized areas of health care delivery. Past research has primarily been designed to examine the role of interpersonal health communication in the two health professional fields of medicine or nursing, neglecting such specialized health service areas as dentistry, physical and occupational therapy, social work, pharmacy, health care administration, and other allied health fields (Thompson, 1984). Certainly interpersonal communication is an operative process in these other areas of health care service. Moreover, interprofessional communication between the

different specialized health fields is an important, yet largely neglected, topic of study (Kreps and Thornton, 1984; Friedson, 1970; Frank, 1961).

Past research have tended to neglect several important populations of health care consumers, among the most important populations being the aged (Kreps, 1985b). The aged are by far the largest group of health care consumers in the United States (Pegels, 1980). As people grow old their physical conditions weaken and they are more heir to health care problems than their younger counterparts (Weg, 1975). Moreover, the health care problems the elderly face are often chronic and debilitating necessitating long-term health care treatment, often to the point of institutionalization within health care and quasi-health care service organizations like hospitals, sanitariums, convalescent homes, or nursing homes. The aged suffer from serious interpersonal health communication problems due to issues of stigmatization, paternalism, alienation, boredom, and fraud (Kreps, 1985b). Future research should be designed to ewxamine the health communication needs of the aged.

Past research have also focussed more on description of interpersonal health communication patterns, issues, and problems, than they have on examining specific directions for improving interpersonal health communication. Given the recent disciplinary development in health communication and the relativly small body of interpersonal health communication

research it seems eminently reasonable that such study should justifiably take a descriptive approach. Certainly we would expect and want health care providers to diligently diagnose health care problems before prescribing health care remedies. Applied communication research should work in a similar fashion, describing the nature of health communication issues before prescribing strategies for improvement. By doing a good job of description we can be confident that the improvement strategies we design are appropriate to the specific problems that limit the effectiveness of interpersonal health communication. The agenda for future research on health communication should address our current state of disciplinary development and description of interpersonal health communication. Work needs to be done to identify what it is we presently know about interpersonal communication in health care, categorizing and integrating research findings, and initiating a move in health communication research from an emphasis on description to emphases on application and development. A fruitful area for such application and development is in the identification and implementation of interpersonal communication competencies for health care providers and consumers.

Health Communication Competencies: A Research Agenda

Both health care providers and consumers depend on their communication to gather information in health care situations.

However, the role of communication and information in health care is so ubiquitous, equivocal, and pervasive that it is often taken for granted, and complexities and subtleties of health communication are often unnoticed, incompletely analyzed, and ineffectively used (Kreps and Thornton, 1984). Communication competency, the ability to effectively utilize informational and interpersonal relations skills, is as important for health care providers and consumers as technical competence (Ruben, 1976).

Past research supports the need for health communication competencies. In summarizing the findings of past research on interpersonal aspects of health care (discussed earlier in this paper) studies clearly demonstrate that the effectiveness of interpersonal communication relationships established between health care providers and consumers have a major influence on the level of success of health care treatment. The provider-client relationship exerts a strong influence on the outcomes and satisfaction people derive from health care experiences. Human communication processes enable health care consumers and providers to gather and interpret pertinent information for accomplishing health care delivery objectives. Competent communication encourages cooperation between health care providers and consumers, and enables the sharing of relevant information necessary to accomplish health evaluation and maintenance (Babbie, 1973).

Considerable research have focussed on communication

competence, especially the nature of communication competence and the manner in which communication competencies are developed in different social contexts (Bochner and Kelly, 1974; Bostrom, 1984; Spitzberg and Cupach, 1984). This research indicates that communication competence is a multi-dimensional construct based on a wide-range of communication abilities that are developed from a combination of communication knowledge and skills. Communication competence is situationally-bound and depends on the abilities of communicators to adapt to one another in specific relational settings (Ruben, 1976).

Several studies have attempted to identify various dimensions of communication competence that are important in specific contexts, such as display of empathy (Carkhuff, 1969; Fine and Therrien, 1977; Rogers, 1961), non-judgmental listening (Cline, 1983; Gibb, 1961; Ruben, 1979), display of respect (Rogers, 1961; Ruben, 1979), informational congruence between message intended and message received (Powers and Lowry, 1984), and interaction management (Wiemann, 1977; Ruben, 1979). By integrating findings of past research on interpersonal aspects of health communication we can begin identifying interpersonal health communication competencies.

Health care provider and consumer communication competencies can help improve the quality of health care and can increase the satisfaction consumers and providers derive from health care situations (Morse and Piland, 1981; Worobey and Cummings, 1984;

Kreps and Thornton, 1984; Cline and Cardosi, 1983; Cline, 1983). Future research should be designed to: (1) identify the specific communication competencies needed by those people involved in digestive disease health care; (2) establish performance-based measures for health communication competencies, and; (3) develop educational strategies to help health care consumers and providers cultivate the health communication competencies identified.

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